

U.S. COURT OF
FEDERAL CLAIMS

² The Program comprises Part 2 of the National Childhood Vaccine Injury Act of 1986, Pub. L. No. 99-660, 100 Stat. 3755, codified as amended, 42 U.S.C. §§ 300aa-10 *et seq.* (hereinafter “Vaccine Act” or “the Act”). Hereafter, individual section references will be to 42 U.S.C. § 300aa of the Act.

vaccine or vaccines listed on the Vaccine Injury Table. On January 7, 2013, Petitioner was ordered to inform the court of how she wished to proceed with her claim within 30 days of the date of that order. Petitioner did not respond to that order.

On January 30, 2013, Petitioner was ordered to file, by no later than February 27, 2013, any evidence demonstrating that the petition should not be dismissed as untimely. This order stated that a failure to meet the deadline would result in dismissal of the claim. The order was sent to Petitioner by certified mail, and Petitioner again failed to respond.

I

BACKGROUND

This case concerning Michael Spadafore is one of more than 5,000 cases filed under the Program in which it has been alleged that a child's disorder known as "autism," or a similar disorder, was caused by one or more vaccinations. A brief summary of one aspect of that history is relevant to this Decision.

A. The Omnibus Autism Proceeding

In anticipation of dealing with such a large group of cases involving a common factual issue--*i.e.*, whether vaccinations can cause autism--the Office of Special Masters ("OSM") devised special procedures. On July 3, 2002, the Chief Special Master, acting on behalf of the OSM, issued a document entitled the Autism General Order # 1, 4 which set up a proceeding known as the "Omnibus Autism Proceeding" (OAP). In the OAP, a group of counsel selected from attorneys representing petitioners in the autism cases, known as the Petitioners' Steering Committee ("PSC"), was charged with obtaining and presenting evidence concerning the general issue of whether those vaccines can cause autism, and, if so, in what circumstances. The evidence obtained in that general inquiry was to be applied to the individual cases. (Autism General Order # 1, 2002 WL 31696785, at *3, 2002 U.S. Claims LEXIS 365, at *8.)

Ultimately, the PSC elected to present two different theories concerning the causation of autism. The first theory alleged that the measles portion of the MMR vaccine can cause autism, in situations in which it was alleged that thimerosal-containing vaccines previously weakened an infant's immune system. That theory was presented in three separate Program "test cases," during several weeks of trial in 2007. The second theory alleged that the mercury contained in the thimerosal-containing vaccines can directly affect an infant's brain, thereby substantially contributing to the development of autism. The second theory was presented in three additional "test cases" during several weeks of trial in 2008.

On February 12, 2009, decisions were issued concerning the three "test cases" pertaining to the PSC's first theory. In each of those three decisions, the petitioners' causation theories were rejected. I issued the decision in *Cedillo v. HHS*, No. 98-916V, 2009 WL 331968 (Fed. Cl. Spec. Mstr. Feb. 12, 2009). Special Master Patricia Campbell-Smith issued the decision in *Hazlehurst*

v. *HHS*, No. 03-654V, 2009 WL 332306 (Fed. Cl. Spec. Mstr. Feb. 12, 2009). Special Master Denise Vowell issued the decision in *Snyder v. HHS*, No. 01-162V, 2009 WL 332044 (Fed. Cl. Spec. Mstr. Feb. 12, 2009).

Those three decisions were later each affirmed in three different rulings, by three different judges of the U.S. Court of Federal Claims. *Hazlehurst v. HHS*, 88 Fed. Cl. 473 (2009); *Snyder v. Secretary of HHS*, 88 Fed. Cl. 706 (2009); *Cedillo v. HHS*, 89 Fed. Cl. 158 (2009). Two of those three rulings were then appealed to the U.S. Court of Appeals for the Federal Circuit, again resulting in affirmances of the decisions denying the petitioners' claims. *Hazlehurst v. HHS*, 604 F. 3d 1343 (Fed. Cir. 2010); *Cedillo v. HHS*, 617 F. 3d 1328 (Fed. Cir. 2010).

On March 12, 2010, the same three special masters issued decisions concerning three separate "test cases" pertaining to the petitioners' second causation theory. Again, the petitioners' causation theories were rejected in all three cases. *King v. HHS*, No. 03-584V, 2010 WL 892296 (Fed. Cl. Spec. Mstr. Mar. 12, 2010); *Mead v. HHS*, No. 03-215V, 2010 WL 892248 (Fed. Cl. Spec. Mstr. Mar. 12, 2010); *Dwyer v. HHS*, No. 03-1202V, 2010 WL 892250 (Fed. Cl. Spec. Mstr. Mar. 12, 2010). None of the petitioners elected to seek review any of those three decisions.

II

PROCEDURAL HISTORY

On April 15, 2008, the court issued an Order directing Petitioner to file, within ninety days: all medical records relating to Michael's autism. (Order, Apr. 15, 2008 at 5.) That order also directed Petitioner to file a "Statement of Completion" once Petitioner had filed all of the medical records required by the Order. Further, the Order directed Respondent to file a "Statement Regarding Whether the Claim Should Proceed in [the] OAP," within forty-five days of the filing of Petitioner's records. (*Id.*) On July 10, 2008, Petitioner filed some medical records but failed to file a Statement of Completion at that time.

Respondent filed a Statement on August 4, 2008, identifying deficiencies of the record and requesting that they be remedied. (Statement at 3.)

On November 17, 2008, Petitioner filed a response to Respondent's Statement and an additional exhibit of medical records. Petitioner also filed a Statement of Completion, which notes that "Petitioners [sic] have submitted all medical records known to be available to them." (ECF No. 16.) On December 22, 2008, I ordered Respondent to reply to Petitioner's response, and on January 16, 2009, Respondent filed a Motion to Dismiss indicating that, "a preponderance of the evidence in the record establishes that Michael's ASD manifested in March 1999, and the petition is therefore time-barred." (ECF No. 19.)

On February 2, 2009, Petitioner filed a Response to Respondent's Motion to Dismiss alleging that despite the fact that Michael stopped talking, Michael exhibited no

other collective impairment in verbal and nonverbal impairment. (Response at 6.) Petitioner asserted that “stopped talking” is not sufficient to be classified as a symptom of autism because to exhibit a symptom of autism, a patient must exhibit a combination of three behavioral characteristics, or at least signs of these characteristics. (*Id.*)

On January 7, 2012, Petitioner’s counsel filed a Motion for Attorney Fees and a Motion to Withdraw as Attorney. (Motion, ECF No. 22.) On January 7, 2013, I issued an order granting Petitioner’s counsel’s Motion to Withdraw. (Order, ECF No. 26.) On January 7, 2013, I also issued an order stating that Petitioner must inform the Court within 30 days of the date of the order of how she wished to proceed. (Order, ECF No. 27.) Petitioner did not respond to that order.

On January 30, 2013, I issued an Order to Show Cause for why this petition should not be dismissed as untimely filed. (Order, ECF No. 28.) This order stated that failure to meet this deadline will result in dismissal of the claim. (*Id.*) Petitioner did not respond to this order.

III

FACTUAL HISTORY

Michael was born on October 4, 1997. (Petition (“Pet”) at 4.) Between October 5, 1997, and January 5, 1999, Michael received routine childhood vaccinations. (Pet. at 4.)

The medical records indicate that Michael initially had a febrile urinary tract infection upon delivery, and was seen in St. Joseph’s Hospital and subsequently admitted to the Mary Bridge Hospital. (Pet. Ex. 5 at 3.) Michael was thereafter treated with antibiotics and discharged. (*Id.*)

One month later, in November 1997, the medical records note that Michael was admitted and discharged from St. Joseph’s Medical Center for “low grade fever.” (Pet. Ex. 1 at 3.) He was noted to have been “sneezing since birth, but he has had no diagnosed medical problems.” (*Id.*)

In December 1997, Michael presented to Dr. Kevin Ghandi, and was diagnosed with “[u]rinary tract infection secondary to grade I reflux on the left.” (Pet. Ex. 5 at 3.) One month later, on January 9, 1998, Michael presented to Dr. Ghandi again for an evaluation, and was found have a rash that persisted for several weeks. (*Id.*) Upon examination, Dr. Ghandi’s impression was “[c]omplete resolution of rash.” (*Id.*)

On October 13, 1999, Michael was examined by a trans-disciplinary team at the Special Children’s Clinic in Reno, Nevada, regarding progressive behavioral issues that

had manifested in Michael. (*See* Pet. Ex. 8.) During the assessment, Lynn Kinman, M.D., conducted a pediatric examination and diagnosed Michael with autism spectrum disorder (“ASD”). (*Id.* at 7.) Dr. Kinman noted that “[s]everal clinicians [had] suggested to the mother that perhaps [Michael was autistic]”, and that prior to March 1999, Michael had approximately six words and interacted with others; however, at the current time, Michael played alone, avoided people, and no longer spoke. (*Id.* at 5.) This assessment report also indicated that Michael was referred to the Special Children’s Clinic by Lisa Lottritz, a community health nurse, who was concerned about Michael’s hearing and speech. (*Id.* at 1-2.) The report noted that Michael’s family first observed that Michael stopped talking in March 1999, when the family moved from Reno to Washington. (*Id.* at 2.)

IV

DIAGNOSTIC CRITERIA FOR AUTISM SPECTRUM DISORDERS

No evidence concerning the diagnostic criteria for autism spectrum disorders was filed by the parties in this case. Accordingly, I have relied upon the information set forth below in this Section IV of this Decision, which is drawn from OAP test case testimony provided by three pediatric neurologists with considerable experience in diagnosing ASDs. I further note that the information in this section was first compiled and published by my colleague, Special Master Vowell, in *White v. HHS*, 04-337V, 2011 WL 6176064 (Fed. Cl. Spec. Mstr. Nov. 22, 2011).

“The terms ‘autism’ and ‘autism spectrum disorder’ have been used to describe a set of developmental disorders characterized by impairments in social interaction, impairments in verbal and non-verbal communication, and stereotypical restricted or repetitive patterns of behavior and interests.” (*Cedillo*, 2009 WL 331968, at *7 (Fed. Cl. Spec. Mstr. Feb. 12, 2009) (an OAP “test case.”)) The specific diagnostic criteria for ASD are found in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 4th ed. text revision 2000 (“DSM-IV-TR”), the manual used in the United States to diagnose dysfunctions of the brain. (*See* testimony in *Cedillo* (“*Cedillo* Tr.”) at 1278A.6) The manual identifies the behavioral symptoms recognized by the medical profession at large as symptoms of ASD.⁷ The DSM-IV-TR contains specific diagnostic criteria for autistic disorder, Asperger’s disorder, and pervasive developmental disorder-not otherwise specified (most frequently referred to as (“PDD-NOS”)). It is not uncommon for parents and even health care providers to use these terms in non-specific ways, such as referring to a child as having an “autism diagnosis,” even though the specific diagnosis is PDD-NOS. Of note, a child’s diagnosis within the autism spectrum may change from autistic disorder to PDD-NOS (or vice versa) over time.

A. Diagnosing Autism Spectrum Disorders

The behavioral differences in autism spectrum disorders encompass not only delays in development, but also qualitative abnormalities in development. (*Cedillo* Tr. at 1264A, 1589-91.) There can be wide variability in children with the same diagnosis. One child might lack language

at all, while another with a large vocabulary might display the inability to engage in a non-scripted conversation. (*Cedillo* Tr. at 1602A-1604.) However, both would have an impairment in the communication domain.

Testing for the presence of an ASD involves the use of standardized lists of questions about behavior directed to caregivers and parents, as well as observations of behaviors in standardized settings by trained observers. (*Cedillo* Tr. at 1272A-74A.) One behavioral symptom alone, such as hand-flapping, would not be diagnostic of an ASD, but if present, it would be a symptom that would be part of the diagnostic picture. As one expert explained, in diagnosing an ASD, “we try to observe symptoms, and when we have observed enough symptoms, then we see if the child meets these criteria.” (*Cedillo* Tr. at 1278A-79; *see also* testimony in the *King* OAP test case (“*King* Tr.”) at 3253-54 (describing diagnostic instruments and their use in clinical settings); *King*, 2010 WL 892296.)

Typically in children with autism spectrum disorders, the symptoms have been present for weeks or months before parents report them to health care providers. (*Cedillo* Tr. at 1283.) The most common age at which parents recognize developmental problems, usually problems in communication or the lack of social reciprocity, is at 18-24 months of age. (*King* Tr. at 3259-60.) The development of symptoms of an ASD occurs very gradually, and it is not uncommon for the parents to be unable to date the onset very precisely. (*Cedillo* Tr. at 1285A-1286A.)

1. Autistic Disorder (Autism)

A diagnosis of autistic disorder requires a minimum of six findings from a list of impairments divided into three domains of impaired function: (1) social interaction; (2) communication; and (3) restricted, repetitive, and stereotyped patterns of behavior, interests, and activities. At least two findings related to social interaction and at least one each in the other two domains are required for diagnosis. To meet the diagnostic criteria for autism, the child must have symptoms consistent with six of the twelve listed types of behavioral impairments. Furthermore, the abnormalities in development must have occurred before the age of three. (*Cedillo* Tr. at 1264A, 1279, 1618; *King* Tr. at 3250.) Although the majority of children with autism have developmental delays, many are of normal intelligence. (*Cedillo* Tr. at 1276; *King* Tr. at 3256.) In testimony in the *Cedillo* OAP test case, one expert described the three domains as the “core features” of a diagnosis on the autism spectrum. (*Cedillo* Tr. at 1589-92.) Children with autism are most symptomatic in the second and third years of life. (*Cedillo* Tr. at 1618.)

2. Pervasive Developmental Disorder-Not Otherwise Specified

The DSM-IV-TR defines PDD-NOS as “a severe and pervasive impairment in the development of reciprocal social interaction,” coupled with impairment in either communication skills or the presence of stereotyped behaviors or interests. (DSM-IV-TR at 84.) The diagnosis is made when the criteria for other autism spectrum disorders, or other psychiatric disorders, such as schizophrenia, are not met. (*Id.*) It includes what has been called “atypical autism,” which includes conditions that present like autistic disorder, but with onset after age three, or which fail

to meet the specific diagnostic criteria in one or more of the domains of functioning. (*Id.*) As was noted in the *Dwyer* OAP test case, this is the most prevalent of the disorders on the autism spectrum. (*Dwyer*, 2010 WL 892250, at *30.)

3. Asperger's Disorder

Asperger's syndrome is a form of high-functioning autism. It presents with significant abnormalities in social interaction and with restricted, repetitive, and stereotyped patterns of behavior, interests, and activities. (*See* DSM-IV-TR at 84.)

B. The Domains of Impairment and Specific Behavioral Symptoms

1. Social Interaction Domain

This domain encompasses interactions with others. (*Cedillo* Tr. at 1264A.) There are four subgroups within this domain. (*Id.* at 1594.) The subgroups include: (1) a marked impairment in the use of nonverbal behavior, such as gestures, eye contact and body language; (2) the failure to develop appropriate peer relations; (3) marked impairment in empathy; and (4) the lack of social or emotional reciprocity. (*Id.* at 1594-96.) To be diagnosed with autism (autistic disorder), the patient must have behavioral symptoms from two of the four subgroups. (*Id.* at 1594.) For an Asperger's diagnosis, there must be two impairments in this domain as well. (DSM-IV-TR at 84.) Children who do not display "the full set of symptoms" are diagnosed with PDD-NOS. (*Cedillo* Tr. at 1275A.) Symptoms used to identify young children with impairments in the social interaction domain include lack of eye contact, deficits in social smiling, lack of response to their name, and the inability to respond to others. (*Cedillo* Tr. at 1269A-70A.)

One expert described the degrees of impairment in interactions with others as a continuum, with affected children ranging from socially unavailable to socially impaired. A child who is socially unavailable may exhibit such behaviors as failing to seek consolation after injury or purposeless wandering, or may simply appear isolated. (*Cedillo* Tr. at 1598.) A less impaired child might be socially remote, responding to an adult's efforts at social interaction, but not seeking to continue the contact. This child might roll a ball back and forth with an adult, but will not protest when the adult stops playing. (*Cedillo* Tr. at 1599.) Given a choice between playing with peers and playing by himself, a child with impairments in social interaction will play by himself. (*Id.*) Some children with ASD demonstrate socially inappropriate interactions, such as pushing other children in an effort to interact. (*Cedillo* Tr. at 1600.) A higher functioning child might attempt interaction, but does so as if reading from a script. As an example, Dr. Wiznitzer discussed a patient who, when asked where he lived, could not answer, but responded appropriately when Dr. Wiznitzer asked the child for his address. (*Id.* at 1601.)

2. Communication Domain

The communication domain involves both verbal and non-verbal communication, such as intonation and body language. (*Cedillo* Tr. at 1263, 1602A.) Language abnormalities in ASD encompass not only delays in language acquisition, but the lack of capacity to communicate with others. (*Id.* at 1267A.) Impaired communication abilities are one of the “most important and early recognized symptoms” of autism. (*Dwyer*, 2010 WL 892250 at *31.)

There are four criteria within the communication domain. (*Cedillo* Tr. at 1602A.) They include: (1) a delay in or lack of development in spoken language, without the use of signs or gestures to compensate; (2) problems in initiating or sustaining conversation; (3) stereotypic or repetitive use of language, including echolalia and repeating the script of a video or radio presentation, such as singing a commercial jingle; and (4) the lack of spontaneous imaginative or make-believe play. (*Cedillo* Tr. at 1602A-05.)

Language delay, limited babbling, lack of gestures, lack of pointing to communicate things other than basic wants and desires (lack of “protodeclarative” vs. “protoimperative” pointing), are all early symptoms used to diagnose impairments in the communication domain. (*Cedillo* Tr. at 1266A-68A.) One expert described the failure to share discoveries via language in autistic children as well. (*Cedillo* Tr. at 1606A.) Children with ASD who have more developed language skills may display difficulties in social communication outside their limited area of interest. (*Id.* at 1607.)

Within the communication domain, children with ASD have difficulties in joint attention, which one expert described as sharing an action or activity with another person or even an animal. They have problems with what he called metalinguistic skills, referring to the meaning behind the language used, which may be conveyed by tone, body language, humor, or sarcasm. Children with ASD may understand visual humor, illustrated by the cartoon of an anvil falling on the coyote’s head, but lack the ability to understand a joke. (*Cedillo* Tr. at 1607-09.) They focus on the literal, rather than figurative, meaning of words: telling a child with ASD to “hop to it” may elicit hopping, rather than an increase in speed in completing a task. These children use language primarily for getting their needs met. (*Id.* at 1609.) A child with ASD might lead a parent to the cookie jar, but would not lead a parent to a caterpillar crawling along the sidewalk.

Children with ASD often have impairments in specific types of play. They may understand cause and effect play, but have difficulties in imitative or representational play. They can push a button to make a toy figure pop up, but have difficulty with holding a tea party, putting a stuffed animal to bed, or feeding a doll. (*Cedillo* Tr. at 1610-11.) They also have impairments in symbolic play, in which an object such as a stick represents another object, such as a magic wand or sword. (*Id.* at 1612.)

Speech and language delays are the symptoms most commonly reported by parents as a concern leading to a diagnosis of ASD. (*See Cedillo* Tr. at 1284 (one of first concerns noted by

parents is the lack of language development); *King Tr.* at 3253 (problems in social and communication domains tend to be observed much earlier than stereotyped behaviors.))

A deficit in at least one of the subgroups in the communication domain is required for an autism diagnosis. (*Cedillo Tr.* at 1602A-1603.) An Asperger's diagnosis does not require communication domain impairment. (*Id.* at 1275A-76.) A PDD-NOS diagnosis requires an impairment in either this domain or the patterns of behavior discussed next. (*Id.* at 1592.)

3. Restricted, Repetitive and Stereotyped Patterns of Behavior Domain

There are four categories within this domain. They include (1) a preoccupation with an interest that is abnormal in intensity or focus, such as spinning a plate or a wheel or developing an intense fascination with a particular interest, such as dinosaurs, cartoon characters, or numbers; (2) an adherence to nonfunctional routines or rituals, such as eating only from a blue plate, sitting in the same seat, or walking the same route; (3) stereotypic or repetitive motor mannerisms, such as finger flicking, hand regard, hand flapping, or twirling; and (4) a persistent preoccupation with parts of an object, such as focusing on the wheel of a toy car and spinning it, rather than playing with the toy as a car. (*Cedillo Tr.* at 1613A-15, 1271A-72A.)

As one expert explained, this domain reflects abnormalities in the way play skills develop, as well as repetitive and rigid behavior. (*Cedillo Tr.* at 1264A.) A typical toddler may flick a light switch a few times, but the child with ASD performs the same action to excess. (*Cedillo Tr.* at 1616.) Another expert described one child who would not turn right; to make a right turn at a crossroads, he would have to make three left turns. (*King Tr.* at 3252-53.)

For a diagnosis of autism, a child must display behaviors in at least one of the categories included in this domain. (*Cedillo Tr.* at 1613A.) An Asperger's diagnosis also requires at least one behavioral impairment encompassed in this domain. (*Id.* at 1275A-76.) A PDD-NOS diagnosis requires either an impairment in this domain or an impairment in the communication domain. (*Id.* at 1592.)

C. Summary

The OAP evidence establishes that a diagnosis of ASD is based on observations of behavioral symptoms. The symptoms are categorized into three domains. For a definitive diagnosis of autism, the child must display behavioral abnormalities in each of the domains, and must exhibit at least six of the 12 behavioral criteria in the three domains. There must be at least two behaviors encompassed in the social interaction domain, reflecting the importance of impaired social interaction in diagnosing ASD. The behavioral abnormalities must manifest before the age of three.

Thus, the absence of any specific symptom would not rule out the diagnosis, so long as the requisite numbers of impairments in each domain of functioning are present. Conversely, autism cannot be diagnosed by any single abnormal behavior, but the ultimate diagnosis is based

on an accumulation of symptomatic behaviors. The existence of any one behavioral abnormality associated with autism is sufficient to trigger the running of the statute of limitations.

For a diagnosis of Asperger's disorder, the child must display behavioral abnormalities similar to those of children with autistic disorder, but need not have a language abnormality. (*Cedillo* Tr. at 1275A-76; *see also* DSM-IV-TR at 84 (requiring two impairments in social interaction and one in restricted, repetitive, and stereotyped patterns of behavior, interests, and activities for this diagnosis.))

For a PDD-NOS diagnosis, the child must display behavioral abnormalities in all three domains. However, this diagnosis is given when the impairments fall short of the criteria required for a diagnosis of autism (autistic disorder). (*Cedillo* Tr. at 1275A.)

V

LEGAL STANDARD

The Vaccine Act provides that:

a vaccine set forth in the Vaccine Injury Table which is administered after October 1, 1988, if a vaccine-related injury occurred as a result of the administration of such vaccine, no petition may be filed for compensation under the Program for such injury after the **expiration of 36 months** after the date of the occurrence of the first symptom or manifestation of onset or of the significant aggravation of such injury***.

(§ 300aa-16(a)(2) (emphasis added)). In *Cloer*, the Court of Appeals for the Federal Circuit affirmed that the “statute of limitations begins to run on a specific statutory date: the date of occurrence of the first symptom or manifestation of onset of the vaccine-related injury recognized as such by the medical profession at large.” (654 F.3d at 1340.) The date of the occurrence of the first symptom or manifestation of onset “does not depend on when a petitioner knew or reasonably should have known” about the injury. (*Id.* at 1339.) Nor does it depend on the knowledge of a petitioner as to the cause of the injury. (*Id.* at 1338.)

VI

ANALYSIS OF THIS CASE

First, I will briefly address why Petitioner's claim is untimely filed, and then I will discuss why this case should also be dismissed for failure to prosecute.

A. This Claim Was Not Timely Filed.

The medical records and statement filed by Petitioner on November 17, 2008, appear to establish that this claim was untimely filed. The petition was filed on April 5, 2002. Therefore, to be considered timely filed under the Vaccine Act's statute of limitations, the first medically recognized sign or symptom of Michael's autism must have occurred no earlier than April 5, 1999. However, the medical records demonstrate that Michael was exhibiting symptoms of autism prior to that date. In fact, a report of Michael's own family recorded in the medical records indicates that Michael exhibited symptoms of autism in *March 1999*, when he was 18 months old. That report, of Michael's family, is recorded in the medical records of an examination that Michael underwent on October 13, 1999, when he was brought to the Special Children's Clinic (SCC) Trans-disciplinary Play-Based Assessment Team to determine whether he was autistic. (Pet. Ex. 8 at 1, 5.) During that examination, Dr. Kinman described in detail Michael's symptoms of autism exhibited at that time. (Pet. Ex. 8 at 5-7.) Most importantly, the records specify that Michael's family observed that he stopped talking in *March 1999*, when the family moved from Reno to Washington. (*Id.* at 2.)

In sum, Michael's medical records seem to establish that this claim was not timely filed, because Michael began exhibiting symptoms of an autism spectrum disorder (i.e., he stopped talking) during March 1999. (Pet. Ex. 8 at 2.) Because the first symptoms of Michael's autism occurred earlier than April 5 1999, the petition was not timely filed on April 5, 2002.

B. Failure to Prosecute

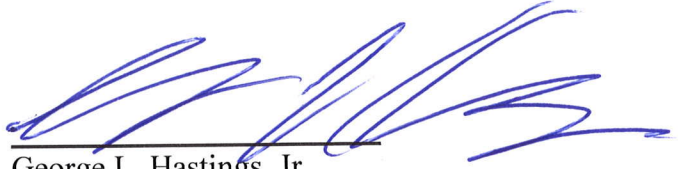
It is Petitioner's duty to respond to court orders. As I reminded Petitioner in my orders of January 7, 2013, and January 30, 2013, failure to follow court orders shall result in dismissal of Petitioner's claim. *Tsekouras v. Sec'y, HHS*, 26 Cl. Ct. 439 (1992), *aff'd per curiam*, 991 F.2d 810 (Fed. Cir. 1993); *Sapharas v. Sec'y, HHS*, 35 Fed. Cl. 503 (1996); Vaccine Rule 21(b). However, Petitioner in this case failed to respond to my orders of January 7, and January 30, 2013, so it is appropriate to dismiss this petition for the additional reason that Petitioner has failed to prosecute the petition.

VII**CONCLUSION**

I have great sympathy for the tragic disorder from which Michael suffers. Under the applicable law, however, Petitioner has the burden to show timely filing. Petitioner has failed to do so. There is preponderant evidence that this case was not filed within "36 months after the

date of the occurrence of the first symptom or manifestation of onset or of the significant aggravation of such injury” as required by the Vaccine Act, § 16(a)(2). Additionally, Petitioner has failed to indicate how she wishes to proceed in this case. **Therefore, this claim is dismissed for failure to prosecute and as untimely filed under the Vaccine Act’s statute of limitations. §16(a)(2). The clerk is directed to enter judgment accordingly.**

IT IS SO ORDERED.


George L. Hastings, Jr.
Special Master